Ekspertiza i razvoj hrvatske politike mentalnog zdravlja: percepcija stručnjaka iz područja mentalnog zdravlja

/ Expertise and Development of Croatian Mental Health Policy: the Perception of Mental Health Professionals

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Prethodna su istraživanja pokazala da hrvatska politika mentalnog zdravlja nije politički prioritet, da joj nedostaje interdisciplinarnosti, međusektorske suradnje i holističkog pristupa. Slijedeći pretpostavku da je jedan od glavnih razloga za takvo polazište niska razina korištenja znanja pri stvaranju politike mentalnog zdravlja, ova studija pokušala je ispitati ulogu ekspertize i prijenosa znanja u razvoju hrvatske politike mentalnog zdravlja. Istraživanje je provedeno metodom *snowball* u proljeće 2018., obuhvatilo je 124 sudionika, stručnjaka iz različitih ustanova koje se bave mentalnim zdravljem. Za potrebe ove studije razvijen je upitnik „Razvoj hrvatske politike mentalnog zdravlja". Prikupljeni kvalitativni i kvantitativni podatci pokazali su da stručnjaci iz sektora mentalnog zdravlja kreiranje politike u svome polju opisuju kao nekvalitetno i u ovisnosti o visokim vladinim tijelima kojima upravlja politička elita nezainteresirana za mentalno zdravlje. Podatci također pokazuju da stručnjaci iz područja mentalnog zdravlja o poboljšanju politike mentalnog zdravlja razmišljaju u skladu s međunarodnim smjernicama. Pa ipak, sebe rijetko smatraju aktivnim činiteljima u procesu kreiranja politike. To nas vodi zaključku da stručnjaci trebaju podršku za umrežavanje, udruživanje radi zagovaranja i bolje međusektorske odnose kako bi utjecali na političku volju.

/ Previous research shows that Croatian mental health policy is not a political priority, that it lacks interdisciplinarity, intersectoral collaboration and a holistic approach. Following the assumption that one of the main reasons for this position is the low level of knowledge in mental health policy-making, this study was set to examine the role of expertise and knowledge translation in Croatian mental health policy development. The study was conducted during spring 2018 and has included 124 participants, professionals from different institutions dealing with mental health, using the snowball method. The questionnaire "Development of Croatian Mental Health Policy" was developed for the purpose of this study. The gathered qualitative and quantitative data shows that professionals in the mental health sector describe policy-making in the field as being of poor quality and highly dependent on top governmental bodies that are run by the political elite uninterested in mental health. The data also proves that mental health professionals in Croatia think about the improvement of mental health policy in line with international guidelines. Still, they rarely consider themselves an active force in policy-making. That leads us to the conclusion that experts and professionals need support to form networks, advocacy coalitions and better inter-sectoral relationships in order to influence the political will.

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UVOD

Suvremena međunarodna i hrvatska politika mentalnog zdravlja

Politika mentalnog zdravlja (PMZ) vrlo je širok pojam koji uključuje sve što država radi u ime mentalnog zdravlja, a što je planirano ili nije, bilo učinkovito ili ne, usmjereno prema bilo kojoj ciljnoj skupini (1). PMZ nužna je za planiranje i usklađivanje svih usluga i aktivnosti, tj. za to da ih se učini eksplicitnima, holističkima i učinkovitima (2). Razvijena PMZ upućuje na jasnu viziju o mentalnom zdravlju stanovništva u budućnosti, sa snažnim vrijednostima i principima koji se očituju u akcijskim planovima države. Učinkovita politika vodi dobrim ishodima u populaciji, poboljšanjima u organizaciji i dostupnosti skrbi, radu za opće dobro kao i uključenosti osoba s mentalnim poteškoćama u zajednicu (2). Svjetska zdravstvena organizacija nudi paket osnovnih smjernica za razvoj politike (2) kojim se rezultati mogu postići unutar pet do deset godina (slika 1). Osim preporuka, naglašava se dvanaest glavnih akcija povezanih s razvojem politike mentalnog zdravlja: promjene u financiranju, zakonodavstvo i ljudska prava, organizacija usluga, ljudski resursi i usavršavanje, promocija, prevencija, tretman

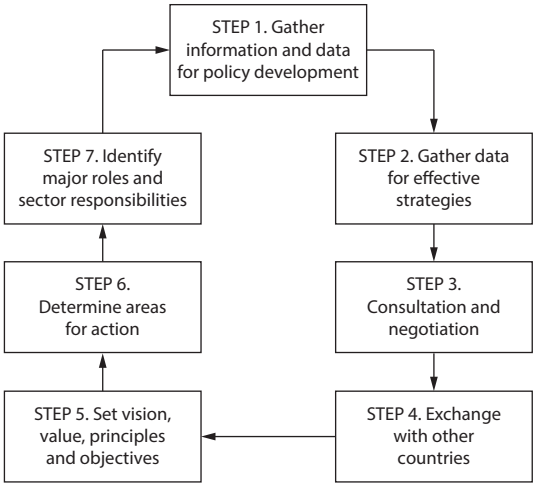

FIGURE 1. World Health Organization's recommendation of steps for mental health policy development. Source: WHO, 2005.

INTRODUCTION

Contemporary international and Croatian mental health policy

Mental health policy (MHP) is a very broad term which includes everything that the state does in the name of mental health, whether planned or not, effective or not, for any target group (1). MHP is essential in order to have a plan and synchronise all services and activities, i.e., to make them explicit, holistic and efficient (2). Developed MHP suggests a clear vision of the future mental health of the population, with strong values and principles reflected in state action plans. Effective policy leads to good population outcomes, improvements in the organization of care, accessibility, community services as well as engagement of people with mental disorders (2). The World Health Organization offers a package of essential guidelines for policy development (2) that could give results within five to ten years (see Figure 1). Apart from recommendations, twelve principal actions for mental health policy action are stressed: changes in financing, legislation and human rights, organization of services, human resources and training, promotion, prevention, treatment and rehabilitation, drug procurement and distribution, advocacy, quality improvement, information systems, research of policies and services and inter-sectoral collaboration (2).

Following that, since mental health is affected by numerous multifaceted factors, modern MHP has to be holistic and multisectoral, extended across different areas, combining health, social and equity approach with economic development (3,4). This means that it should spread outside the health sector and combine parts of several standard governmental sectors. Modern MHP based on a holistic approach to mental health consists of five areas: mental health care and treatment of mental disorders; public health activities and pre-

i rehabilitacija, nabava i distribucija lijekova, zagovaranje, unaprjeđenje kvalitete, informacijski sustavi, istraživanje politike i usluga i međusektorska suradnja (2).

U skladu s time, budući da na mentalno zdravlje utječu brojni višeznačni faktori, moderna PMZ mora biti holistička i multisektorska, protezati se kroz različita područja te s gospodarskim razvojem udruživati zdravstveni i društveni razvoj te pitanja pravednosti (3, 4). To znači da se treba proširiti izvan granica zdravstvenog sektora i kombinirati dijelove nekoliko standardnih vladinih resora. Moderna PMZ utemeljena na holističkom pristupu mentalnom zdravlju sastoji se od pet područja: skrb o mentalnom zdravlju i tretman mentalnih poremećaja; aktivnosti javnog zdravstva i prevencija mentalnih poremećaja; pozitivno mentalno zdravlje za sve i promocija mentalnog zdravlja; socijalne politike za jednakost ljudi s mentalnim poremećajima kao i njihovih obitelji; borba protiv stigmatizacije i diskriminacije sa svrhom dostojanstva i ljudskih prava osoba s mentalnim poremećajima (5,6).

Europski akcijski planovi za mentalno zdravlje ozbiljno su započeli 2005. godine s ministarskom konferencijom u Helsinkiju na kojoj je donesen *Green paper*, prva službena europska politika mentalnog zdravlja (slika 2). Ista je konferencija 2008. godine potvrdila pet prioritetnih područja u dokumentu *European Pact for Mental Health and Wellbeing* (Europski pakt za mentalno zdravlje i blagostanje). Društvene, političke i gospodarske promjene utječu na mentalno zdravlje ljudi širom svijeta te zahtijevaju veću odgovornost: na primjer, imigrantska kriza, nezaposlenost, društvene i zdravstvene nepravdedovode do zapanjujuće posljedice od 28-postotne prevalencije mentalnih poremećaja širom svijeta (3). Shvaćanje da su vlade odgovorne za zdravstvene implikacije svojih odluka te da je mentalno zdravlje populacije ključno za gospodarski napredak postaje dijelom globalnih i europskih akcijskih planova, kao i nužnim dijelom recentnog europskog pokreta *Zdravlje u*

vention of mental disorders; positive mental health for all and promotion of mental health; social policies for equity of people with mental disorders and their families; and fighting stigmatization and discrimination in the name of dignity and human rights of people with mental disorders (5,6).

European mental health action plans started with the 2005 Helsinki ministerial conference and a green paper, the first official European mental health policy (see Figure 2). In 2008 the same conference confirmed five priority areas in the document *European Pact for Mental Health and Wellbeing*. Societal, political and economic changes are affecting mental health of people worldwide and are calling for greater political responsibility: for example, immigration crisis, unemployment, societal and health inequities as well as the astounding consequences of the 28 percent of mental disorders prevalence worldwide (3). The notion that governments are responsible for health implications of their decisions and that the mental health of a population is key to economic progress is becoming part of global and European action plans, as well as an essential component of the latest European movement, *Health in All Policies* (3,4). *Health in All Policies* emphasizes health equity through the importance of consequences of public policies on health systems and crucial determinants of health and progress (4).

Coming back to the Croatian context that is the focus of this paper, Croatian MHP development is not very transparent or clearly described in literature (5,6), official documents or on the web of the Ministry of Health. The latest strategy, *The National Strategy for Mental Health Protection for the Period from 2011 to 2016*, was confirmed in 2010. It has six modern objectives: the promotion of mental health for all, access to mental disorders through preventive activities, the promotion of early intervention and treatment, enhancing life quality

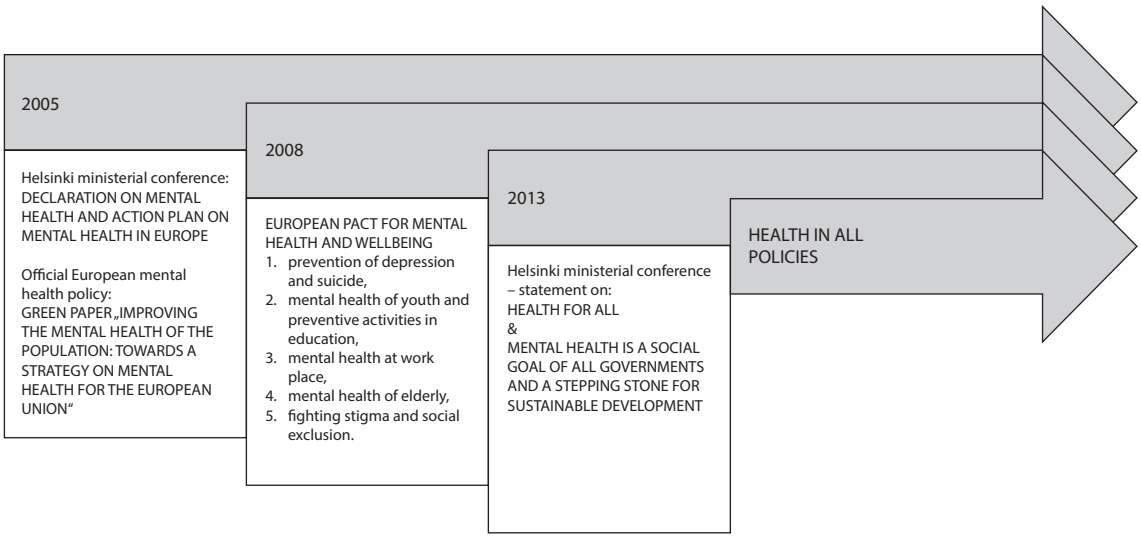

FIGURE 2. Short overview of most important contemporary mental health policy documents

svim politikama (3, 4). *Zdravlje u svim politikama* naglašava pravednost u zdravlju kroz važnost posljedica javnih politika na zdravstvene sustave i ključne odrednice zdravlja i napretka (4).

Vratimo li se hrvatskom kontekstu, koji je u fokusu ovog rada, razvoj hrvatske politike mentalnog zdravlja nije baš transparentan ni jasno opisan u literaturi (5,6), službenim dokumentima ili na web-stranici Ministarstva zdravstva. Posljednja strategija „Nacionalna strategija zaštite mentalnog zdravlja za razdoblje od 2011. do 2016." potvrđena je 2010. godine. Sadrži šest modernih ciljeva: promociju mentalnog zdravlja za sve; otkrivanje mentalnih poremećaja prevencijskim aktivnostima; promociju rane intervencije i tretmana; društvenu inkluziju i posljedično poboljšanje kvalitete života za ljude s mentalnim poremećajima ili invaliditetom; zaštitu ljudskih prava i digniteta; usklađivanje s drugim sličnim ili konkretnim strategijama te razvoj sustava istraživanja i informacija (7). Iako je vrlo usklađena s međunarodnim trendovima, ovu strategiju, koja je i kratka i nedovoljno precizno napisana, nisu slijedili akcijski planovi ili javni izvještaji o njezinoj učinkovitosti.

Mentalno zdravlje djece i mladih također je dio „Strateškog plana razvoja javnog zdravstva

for people with mental disorders or disability through social inclusion, the protection of human rights and dignity, alignment with other similar or specific strategies and the development of research and information systems (7). Although very much in line with international movements, this strategy, apart from being short and not written in a precise manner, was not followed by action plans or public reports on its effectiveness.

The mental health of children and youth is also part of the *Strategic Plan for Public Health Development for the Period from 2013 to 2015* since it includes activities of mental health promotion, prevention of alcohol consumption and early detection of anxiety and depression symptoms in children and adolescents (8). As far as the authors know, since only some colloquial information is circulating, there are two initiatives and working groups taking place now: a working group for the national strategy for mental health of adults and another one for the national strategy for mental health of children and youth. The new strategic plan for public health development is also being developed and is currently in the process of confirmation. There are no precise insights on these issues as this topic is heavily under-researched in Croatia, and

za razdoblje 2013.-2015.“ budući da uključuje aktivnosti promocije mentalnog zdravlja, prevencije konzumacije alkohola i rano otkrivanje simptoma anksioznosti i depresije kod djece i adolescenata (8). Prema onome što je autoricama dostupno, jer o tome postoji tek nešto neformalnih informacija, trenutno postoje dvije inicijative i radne skupine: radna skupina za nacionalnu strategiju za mentalno zdravlje odraslih i još jedna za nacionalnu strategiju za mentalno zdravlje djece i mladih. Novi Strateški plan razvoja javnog zdravstva također je u nastanku, a trenutno je u procesu potvrđivanja. O ovim pitanjima nema preciznijih saznanja budući da je ova tema u Hrvatskoj izrazito slabo istražena te još uvijek ne postoje istraživački projekti ili dostupne baze podataka o razvoju PMZ u Hrvatskoj.

Interdisciplinsko istraživanje hrvatske politike mentalnog zdravlja započele smo tijekom 2011. godine povezujući znanje iz područja promocije mentalnog znanja, prevencijske znanosti i javnih politika. Naša prethodna istraživanja i preliminarni rezultati pokazuju kako se u Hrvatskoj holistički pristup mentalnom zdravlju (4) još ne očituje u politici i da je mentalno zdravlje daleko od toga da bude politički prioritet (5, 6). Naša je pretpostavka da je jedan od glavnih razloga za ovu situaciju niska razina prijenosa znanja pri stvaranju politike mentalnog zdravlja. Kako bismo testirali tu hipotezu osmislili smo istraživanje koje je tema ovog rada, a koje propituje kako opisati ekspertizu u području mentalnog zdravlja i stvaranju politike mentalnog zdravlja u Hrvatskoj te kakva je povezanost korištenja ekspertize i stvaranja politike.

Prijenos znanja i stvaranje politika utemeljeno na dokazima

Često politička praksa i istraživanja u različitim poljima naglašavaju problem slabe uporabe znanja pri stvaranju politika, procijep između istraživanja i javnih politika te spor prijenos

there are still no research projects or available databases on MHP development in Croatia.

We started the interdisciplinary research of Croatian MHP during 2011, combining knowledge from the fields of mental health promotion, prevention science and public policy. Our previous research and preliminary findings show that a holistic approach to mental health (4) in Croatia is still not evident in policy-making and that mental health is far from being a political priority (5,6). We assume that one of the main reasons for this position is the low level of knowledge translation into mental health policy-making. To test this hypothesis, we conducted a study of the description of mental health expertise and mental health policy-making in Croatia and their interrelation.

Knowledge translation and evidence-based policy-making

Quite often political practice and research in different fields stress the problems of low usage of knowledge in policy-making, the gap between research and policy and the slow transfer of new findings into practice, which takes place within messy and complex processes (9-15). Development in diverse policy sectors towards a more successful, more efficient and more effective collective problem-solving is dependent on the incorporation of research findings and expertise into policy practice, which we could generally label as “knowledge-usage” in policy-making.[1]

Coming back to the policy-making cycle constituted by several phases following the logic of problem-solving, knowledge-usage is most important in the phases of policy formulation,

[1] The literature tries to grasp this phenomenon with many terms and concepts such as knowledge translation, knowledge transfer, knowledge brokering, knowledge or innovation uptake, knowledge or innovation diffusion, knowledge or research utilisation, information dissemination, evidence translation, evidence-based policy-making, evidence-informed policy-making and evidence-based management (9,10,12-15,21,22,24,25).

novih saznanja u praksu, koji se odvija kaotičnim i složenim procesima (9-15). U raznolikim javnim politikama razvoj prema uspješnijem – učinkovitijem – kolektivnom rješavanju problema ovisi o uključivanju rezultata istraživanja i stručnih nalaza u političku praksu, tj. o onome što bismo općenito mogli nazvati „korištenjem znanja" pri stvaranju politika[1].

Nekoliko je faza u ciklusu stvaranja politika, a koje slijede logiku rješavanja problema, pri čemu je korištenje znanja najvažnije u fazi formuliranja politike kad ju se tek osmišljava te u fazi evaluacije. Te se dvije faze temelje na ekspertizi, osobito na analizi javnih politika (*policy analysis*) koja koristi znanstvene metode, podatke i argumente –prije odlučivanja kako bi se evaluirale opcije za stvaranje politike i u fazi poslije odlučivanja u kojoj se evaluiraju njezini rezultati (16-20).

Stoga je glavni normativni argument mnogih političara, profesionalaca, znanstvenika, zaposlenika i drugih dionika taj da su više razine korištenja znanja u stvaranju politika ključan preduvjet za kvalitetno stvaranje politika (21). U literaturi su u posljednja dva desetljeća razvijeni mnogi modeli, okviri, strategije, putevi i faze za opisivanje te unaprjeđenje prijenosa znanja u stvaranje politika. Iako je većina radova u tom polju teorijska, postoje i empirijska istraživanja koja su većinom usmjerena na otkrivanje faktora koji utječu na premošćivanje jaza između znanja i javnih politika (21)[2]. To je osobito prisutno u zdravstvenom sektoru budući da politike i postupci utemeljeni na

when a policy is designed, and in its evaluation stage. These two phases are fundamentally based on expertise, especially on policy analysis that uses scientific methods, data and arguments in pre-decision form to evaluate policy options and in post-decision form to evaluate policy results (16-20).

Therefore, the basic normative argument of many politicians, experts, scholars, professionals and other stakeholders is that higher levels of knowledge-usage in policy-making constitute the key prerequisite for quality policy-making (21). The literature in the last two decades has developed many models, frameworks, strategies, pathways and phases to describe and enhance knowledge translation into policy-making. Even though most of the work in the field is theoretical, there have been some empirical studies focusing mostly on detecting the factors that influence closing the gap between knowledge and policy (21).[2] This is present especially in the health sector, since evidence-informed policies and actions can strengthen health systems and the population's health (22).[3] Studies in knowledge translation in the health sector are quite numerous. They stress incorporating knowledge and research findings into different levels of healthcare systems, into the work of professionals, consumers/patients' conduct, policymakers' decision-making and different stakeholders' advocacy (9,23-25).

Enhancing the quality of policy-making by increased usage of knowledge seems especially valid and important for mental health policy. "The involvement of governments in leading the delivery of evidence-based services is vi-

[1] Literatura ovaj fenomen pokušava obuhvatiti mnogim pojmovima i konceptima kao što su prevođenje znanja, prijenos znanja, posredovanje znanja, prihvaćanje znanja ili inovacija, širenje znanja ili inovacija, uporaba znanja i istraživanja, diseminacija informacija, prijenos dokaza, stvaranje politika utemeljeno na dokazima, stvaranje politika informirano dokazima i upravljanje utemeljeno na dokazima (9, 10, 12-15, 21, 22, 24, 25).

[2] Neki naglašavaju da su "glavni faktori koji utječu na uporabu dokaza (a) pristup relevantnim i jasnim informacijama i (b) dobri odnosi između istraživača i korisnika istraživanja", osobito stvaratelja javnih politika (22:5).

[2] Some stress that "the main factors affecting use of evidence are (a) access to relevant and clear information and (b) good relationships between researchers and research users", especially policymakers (22:5).

[3] EBP [evidence-based policy] is sometimes said to have derived from evidence-based medicine (EBM), which dates back at least to 1972, with Archie Cochrane's seminal work on effectiveness and efficiency" (21:1).

dokazima itekako mogu ojačati zdravstvene sustave i zdravlje populacije (22)[3]. Istraživanja prijenosa znanja u zdravstvenom sektoru prilično su brojna. Naglasak stavljaju na uključivanje znanja i rezultata istraživanja u različite razine zdravstvenog sustava, u rad stručnjaka, ponašanje potrošača/pacijenata, donošenje odluka od strane stvaratelja politika i zagovaranje različitih dionika (9,23-25).

Povećavanje kvalitete stvaranja politika putem većeg korištenja znanja čini se osobito opravdanim i važnim za politiku mentalnog zdravlja. „Uključivanje vlada u provedbu usluga utemeljenih na činjenicama ključno je jer je sustav koji pruža usluge za mentalno zdravlje oblikovan inicijativama kao i nedostatkom inicijativa za izvođenje konkretnih tretmana i usluga koji su uključeni u Vladine politike“ (15). No, uspostavljanje i istraživanje procesa stvaranja politike za mentalno zdravlje koje bi se zasnivalo na dokazima,zaostaje za napretkom koji je postignut u zdravstvenom sektoru. Politika mentalnog zdravlja i uloga stvaratelja politika u mentalnom zdravlju općenito su slabo istražene, te su istraživanja o donošenju politika mentalnog zdravlja još uvijek dosta rijetka, mada postoje poneki dobri primjeri (1,26-29).

Malen broj znanstvenika tek je počeo istraživati uporabu dokaza u politici mentalnog zdravlja, ali te su studije i dalje fokusirane na implementiranje konkretnih praksi utemeljenih na dokazima, a ne na sistematičnom istraživanju uporabe znanja i poboljšavanju te uporabe stvaranjem „kulture veće uporabe dokaza među donositeljima odluka u području mentalnog zdravlja općenito“ (15).

U području mentalnog zdravlja prijenos znanja i stvaranje politika utemeljeno na dokazima još uvijek su nova područja istraživanja, obilježena

[3] „Za politiku utemeljenu na dokazima [EPB, engl. *evidence-basedpolicy*] ponekad se kaže da se izvodi iz medicine utemeljene na dokazima (engl. EBM) koja potječe iz barem 1972., tj. od pionirskog djela ArchieaCochranea o učinkovitosti” (21:1).

tal because the mental health service system is shaped by incentives and disincentives to deliver particular treatments and services that are included in government policies” (15). Still, establishing and researching evidence-based mental health policy-making is slowing down the progress achieved in the health sector. Mental health policy and the role of policymakers in mental health in general are poorly researched and studies on mental health policy-making are still quite rare (for some good exceptions see 26-29,1).

Only a small number of scholars have just begun researching the use of evidence in mental health policy, but those studies are still focused on implementing specific evidence-based practices, and not on a systematic investigation of knowledge usage and the enhancement of that usage by the creation of “a culture of greater evidence use among mental health decision makers more generally” (15). In the field of mental health, knowledge translation and evidence-based policymaking is still an emerging area of inquiry, marked with many difficulties, and still more focused on mental health interventions than on mental health policy-making (11,15). This is aggravated by the high complexity and heterogeneity of mental health as an issue; by the low level of maturity of psychiatry, the dominant mental health discipline, especially in comparison to other medical subfields; and by continuing change, the rise and fall of major etiological theories and schools (for factors determining mental health policy-making, see 1:106-113). This paper aims to make a small contribution to the advancement of insights for this huge research gap.

AIM

Since research of MHP in Croatia is exceptionally under-developed, the purpose of our study is that of initial exploration. Its aim is to determine and to describe the main features of

mnogim teškoćama te su i dalje fokusirana više na intervencije u području mentalnog zdravlja nego na stvaranje politika (11, 15). To otežava i znatna složenost te heterogenost mentalnog zdravlja kao teme, niska razina zrelosti psihijatrije, dominantne discipline u području mentalnog zdravlja, osobito u usporedbi s drugim medicinskim disciplinama, te stalna promjena, pojavljivanje i nestajanje glavnih etioloških teorija i škola. Rochefort prikazuje čimbenike koji određuju stvaranje politike mentalnog zdravlja (1). Ovaj je rad doprinos unaprjeđenju tih saznanja s obzirom na veliki nedostatak istraživanja o politici mentalnog zdravlja.

CILJ

Budući da je istraživanje PMZ-a u Hrvatskoj iznimno slabo razvijeno, naša je studija zamišljena kao preliminarna studija. Stoga je njezin cilj odrediti i opisati glavne značajke ekspertize u području mentalnog zdravlja u Hrvatskoj i pri donošenju politike mentalnog zdravlja. Osobita je pažnja usmjerena na odnos ekspertize i stvaranja politike u polju mentalnog zdravlja, kako bi se procijenila razina prijenosa znanja u donošenje odluka te utjecaj znanja na politiku mentalnog zdravlja. Nadalje, svrha je ovoga rada informirati znanstvenu i stručnu zajednicu o ovom ključnom aspektu stvaranja politike mentalnog zdravlja, potaknuti dodatna istraživanja o politici mentalnog zdravlja općenito i konkretno o prijenosu znanja u PMZ-u, te po mogućnosti doprinijeti razvoju politike mentalnog zdravlja u Hrvatskoj u smjeru veće sklonosti k odlučivanju temeljenom na dokazima.

METODE

Složena tema poput upotrebe znanja u stvaranju politika traži sveobuhvatne metode zbog čega je korišten pristup mješovitih metoda, kombinacija kvantitativnog i kvalitativnog

Croatian mental health expertise and mental health policy-making. Special focus is placed onto the relationship between expertise and policy-making in the field of mental health in order to provide a rough estimate of the level of knowledge translation into decision-making and its influence on mental health policy. Furthermore, the purpose of this paper is to inform the debate of the scientific and professional community on this crucial aspect of mental health policy-making; to encourage additional research on mental health policy in general and on knowledge translation in MHP in particular; and to potentially contribute to the development of mental health policy in Croatia in the direction of more inclination towards evidence-based decision-making.

METHODS

Complex issues such as knowledge usage in policy-making seek comprehensive methods, which is why a mixed methods design was used, combining a quantitative and a qualitative approach. Combining qualitative and quantitative data enables a better understanding of the problem and is usually recommended in current studies of health-related behaviour, research of education policy as well as in studies of emotional and behavioural problems (30,31). This approach will enable the triangulation of collected data, its mutual clarification and complementation, thereby securing stronger validity and credibility of results.

We developed the questionnaire "Development of Croatian Mental Health Policy", which consists of 34 items. The first part of the questionnaire covers seven demographic variables that were mostly concerned with professional experience, position, place of work, gender and length of the participants' employment. The second part of the questionnaire deals with expertise in MHP and its influence on policy-making. Ten questions in the expertise part

pristupa. Kombiniranje kvalitativnih i kvantitativnih podataka omogućuje bolje razumijevanje problema i obično se preporučuje u suvremenim istraživanjima ponašanja povezanih sa zdravljem, istraživanjima obrazovnih politika kao i istraživanjima emocionalnih i ponašajnih problema (30,31). Ovakav pristup omogućit će triangulaciju prikupljenih podataka, njihovo međusobno pojašnjavanje i dopunjavanje, a time i snažniju valjanost i vjerodostojnost rezultata.

Za potrebe istraživanja autorice su razvijeupitnik „Razvoj hrvatske politike mentalnog zdravlja"koji se sastoji od 34 čestice. Prvi dio upitnika pokriva sedam demografskih varijabli koje se tiču stručnog iskustva, položaja, mjesta zaposlenja, spola i trajanja zaposlenja sudionika. Drugi dio upitnika pokriva ekspertizu u PMZ-u i utjecaj ekspertize na stvaranje politike. Deset pitanja u tom dijelu koji se bavi ekspertizom otvorenog su tipa. Sudionici su odgovarali na pitanja o svojoj stručnosti, ulozi njihove institucije u razvoju politike mentalnog zdravlja, njihovoj osobnoj ulozi i uključenosti u PMZ, o institucionalnim definicijama mentalnog zdravlja, te o sastavu i ulozi stručnih radnih skupina. Četiri su pitanja bila kategoričkog tipa – sudionici su izražavali stupanj svog slaganja s izjavama na Likertovoj ljestvici od deset stupnjeva. Pitanja su se ticala percepcije institucionalnog i osobnog utjecaja na PMZ, percepcije važnosti ekspertize i znanja u stvaranju PMZ kao i njihove percepcije interdisciplinarnosti toga znanja.

Treći dio upitnika odnosio se na definicije politike mentalnog zdravlja i sastojao od jednog pitanja otvorenog tipa u vezi sa stavovima organizacije prema mentalnom zdravlju te četiri kategorijska pitanja Likertovog tipa. Kategorijska pitanja u tom trećem dijelu pokrivala su percepciju različitih aspekata politike mentalnog zdravlja, preklapanje PMZ s drugim politikama, doživljaj toga jesu li prioriteti određeni na temelju potpunog i obuhvatnog stanja men-

were open-ended and the participants were asked about their expertise, the role of their institution in mental-health-policy development, their personal role and engagement in MHP, institutional definitions of mental health and composition and the role of expert groups. Four questions in the expertise part were categorical and the participants had to choose the level of their agreement with the statements on a ten-point Likert-type scale. Those were the questions regarding the perception of institutional and personal influence on MHP, the extent to which mental health professionals perceive the importance of expertise and knowledge as well as their perception of interdisciplinarity of that knowledge.

The third part of the questionnaire dealt with the definition of mental health policy and included one open-ended question regarding the attitude of organization towards mental health and four categorical Likert-type questions. The categorical questions in the third part covered the perception of different aspects of mental health policy, the overlap of MHP with other policies, the perception of whether priorities are being made upon complete and comprehensive state of the population's mental health and professionals' perception of the greatest challenges in MH action. The fourth and last part of the questionnaire belongs to the implementation section and has eight questions. Six categorical questions asked the participants to assess their level of agreement on a five-point Likert-type scale regarding the mental-health-policy implementation; one categorical question on the evaluation of the policy on a ten-point Likert-type scale; and one open-ended question on mechanisms used by ministries/government as well as improvements that are called for.

Quantitative data was analysed using descriptive statistics as well as group difference statistics. Answers to open-ended questions were processed by an open coding procedure (32-34) for the pur-

talnog zdravlja populacije i percepciju stručnjaka o najvećim izazovima mentalnog zdravlja. Četvrti i zadnji dio upitnika pripada dijelu koji se odnosi na implementaciju i sastoji se od osam pitanja. Šest je kategoričkih pitanja o implementaciji politike mentalnog zdravlja od sudionika tražilo da procjene svoju razinu slaganja na Likertovoj ljestvici od pet stupnjeva; jedno se kategoričko pitanje ticalo evaluacije politike na Likertovoj ljestvici od deset stupnjeva, a jedno se otvoreno pitanje bavilo mehanizmima koje koriste ministarstva/vlada te nužnim poboljšanjima.

Kvantitativni su podatci analizirani deskriptivnom statistikom te su testirane razlike između grupa. Odgovori na pitanja otvorenog tipa obrađivani su postupkom otvorenog kodiranja (32-34) za potrebe razvoja sheme kodiranja. Otvoreno kodiranje je napravljeno odvojeno za svako pitanje, u odnosu na sadržaj pitanja postavljenog sudionicima, pa je razvijena originalna shema kodiranja za svako otvoreno pitanje. Induktivno razvijene sheme kodiranja potom su primijenjene na pripadajuća pitanja pridruživanjem od 1 do 5 kodova odgovoru sudionika, ovisno o sadržaju i dužini odgovora, kako bi se dobile frekvencije pojavljivanja kodova[4].

Postupak i opis uzorka

Upitnik je proveden putem Google obrasca metodom *snowball* namjernog uzorkovanja. Neki od sudionika identificirani su i kontaktirani e-poštom s uključenom poveznicom na upitnik. Pozvani su na sudjelovanje i na pozivanje drugih sudionika tako što će upitnik poslati svojim kolegama koji rade u polju mentalnog zdravlja. Upitnik je ispunilo 124 sudionika, a od toga je 121 odgovor bio potpun i valjan. Upitnik su ispunili različiti stručnjaci koji rade u sustavu mentalnog zdravlja ili na položajima na kojima je mentalno zdravlje djece, mladih i obitelji

[4] Sve tablice kodiranja na upit se mogu dobiti od autorica.

pose of coding scheme development. Open coding was done separately for each question, was guided by the content of the question posed to participants and therefore an original coding scheme was developed for each open-ended question. Inductively developed coding schemes were then applied onto the belonging questions by attaching 1 to 5 codes to a respondent's answer, depending on its content and length, to get frequencies of the codes' occurrence.[4]

Procedure and sample description

The questionnaire was administered online by Google Forms, using the snowball non-probability sampling method. Some of the participants were identified and contacted by e-mail, with a survey link included. They were asked to participate and to recruit others by sending the questionnaire to their colleagues working in the mental health field. The questionnaire was completed by 124 participants, 121 of answers being thorough and valid. The questionnaire was completed by various professionals working in the system of mental health care or in positions where mental health of children, youth and families is of central concern and is included in the job description. The sample is very heterogeneous regarding the institutions included and the level of experience that is fruitful for the goal of this paper. No exclusion criteria were used regarding the participants.

The participants were employees from the psychiatric hospital for children and youth as well as from various Zagreb and other Croatian psychiatric clinical hospitals for adults, regional and national Institutes for Public Health, NGOs, several private practices and counselling centres, family centres, centres for social welfare and child protection, elementary schools and kindergartens. The most prevalent

[4] All coding sheets are available on request from the authors.

glavno područje rada i uključeno je u opis posla. Što se tiče ustanova obuhvaćenih istraživanjem i razine iskustva, uzorak je vrlo heterogen. Nisu korišteni kriteriji za isključivanje sudionika.

Sudionici su zaposlenici psihijatrijske bolnice za djecu i mlade te zaposlenici različitih zagrebačkih i drugih hrvatskih psihijatrijskih kliničkih bolnica za odrasle, regionalnih i nacionalnih instituta javnog zdravstva, nevladinih organizacija, nekoliko privatnih praksi i savjetodavnih centara, obiteljskih centara, klinika za zaštitu djece, osnovnih škola i vrtića. Najzastupljeniji stručnjaci bili su psihijatri zaposleni uglavnom u kliničkom okruženju (n=37), psiholozi (n=32), socijalni pedagozi (n=19), liječnici školske medicine (n=12) i socijalni radnici (n=11). Drugi su stručnjaci manje zastupljeni (slika 3).

U ukupnom uzorku samo je 13 sudionika muškog spola (10,7 %), a 108 ih je ženskog spola (89,3 %). Najmlađi je sudionik imao 25 godina, a najstariji 74, pri čemu je srednja dob 45,13 godina (SD=11,89). Prosječno trajanje zaposlenja je 18,5 godina (SD=11,45). Prosječno trajanje zaposlenja u trenutačnoj ustanovi bilo je 14 godina, ali razlike među sudionicima su velike (minimalno 1 godina, maksimalno 42 godine).

REZULTATI

Rezultati su predstavljeni u četiri dijela, kombiniraju kvantitativne i kvalitativne podatke iz kategorijskih odgovora i odgovora na pitanja otvorenog tipa. Prvi odjeljak posvećen je razumijevanju politike mentalnog zdravlja i predstavlja rezultate otvorenog kodiranja organizacijskih stavova o mentalnom zdravlju te kvantitativne procjene sudionika o multisektorskoj prirodi hrvatske politike mentalnog zdravlja (dio je samo zdravstvenog sektora ili predstavlja i šire pitanje). Drugi odjeljak donosi procjenu trenutačnog stvaranja politike mentalnog zdravlja u Hrvatskoj od stručnja-

professionals were psychiatrists working predominantly in a clinical setting (n= 37), psychologists (n=32), social pedagogues (n=19), school medicine physicians (n=12) and social workers (N=11). Other professions were less represented (see Figure 3).

In the total sample, only 13 participants were male (10.7%) while 108 were female (89.3%). The youngest participant was 25 years old and the oldest was 74 years old, mean age being 45.13 years (SD=11.89). The average length of employment was 18.5 years (SD=11.45). The average length of employment at the current institution was 14 years but differences among participants are large (minimum 1 year and maximum 42 years).

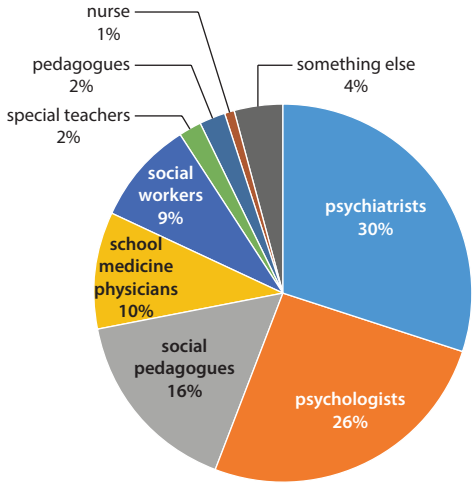

FIGURE 3. Professionals participating in the study

RESULTS

Our results are presented in four sections, combining quantitative and qualitative data from categorical and open-ended answers. The first section is devoted to the understanding of mental health as a policy issue. It presents the results of open coding of organizational attitudes on mental health and quantitative estimation of participants on the multi-sectoral nature of Croatian MHP – is it only a part of the health sector or a wider issue? The second section presents professionals' evaluation of current mental

ka, uključujući i pitanja koliko je stvaranje politike mentalnog zdravlja u Hrvatskoj sistematsko i holističko; najvažnije izazove i ograničenja za stvaranje politike mentalnog zdravlja; stavove o različitim karakteristikama implementacije mentalnog zdravlja u Hrvatskoj danas i preporuke stručnjaka za unaprjeđenje PMZ.

Rezultati se nastavljaju s dijelom koji se bavi ulogom ekspertize u stvaranju politike mentalnog zdravlja u Hrvatskoj. Taj odjeljak donosi nalaze o institucijskoj i individualnoj uključenosti u stvaranje politike, razvijene kodiranjem pitanja otvorenog tipa te podatke o sudjelovanju stručnjaka u radnim skupinama kao specifičnom obliku utjecaja ekspertize na stvaranje politika. Zadnji, četvrti, dio bavi se tipom upotrijebljenog znanja i njegovim utjecajem na hrvatsku PMZ. Stoga u tom odjeljku predstavljamo kako naši sudionici procjenjuju vlastiti utjecaj i utjecaj njihove institucije na stvaranje politike te koliko općenito stručno znanje ima utjecaja na hrvatsku PMZ. Ovaj odjeljak donosi i procjene koliko vlada prikuplja podatke o politici mentalnog zdravlja što je ključan korak u stvaranju politike utemeljenom na dokazima, te u kojoj mjeri je znanje upotrijebljeno u hrvatskoj politici mentalnog zdravlja interdisciplinarno.

Definiranje hrvatske politike mentalnog zdravlja

Sudionici su u obliku pitanja otvorenog tipa zatraženi da opišu stavove svoje institucije prema politici mentalnog zdravlja. To nam je omogućilo usporedbu stavova hrvatskih institucija s međunarodnim smjernicama, što je vrlo relevantno jer su sve institucije iz uzorka akteri hrvatske PMZ. Za analizu odgovora na ovo pitanje indukcijski smo razvili 11 kodova koji su na odgovore sudionika primijenjeni 136 puta i koji se mogu podijeliti u tri skupine koje predstavljaju tri aspekta institucijskih stavova.

health policy-making in Croatia, including questions on how much MH policy-making in Croatia is systematic and holistic; the most important challenges and burdens for MH policy-making; views on different features of MH implementation in Croatia today and professionals' recommendations for MHP improvements.

The results continue with the section on the roles of expertise in Croatian MH policy-making. This next section presents findings on institutional and individual involvement in policy-making, developed through coding of open-ended questions, and data on expert working groups membership as a specific form of expertise influence on policy-making. The final, fourth section deals with the type of knowledge that is used and its influence on Croatian MHP. Therefore, in this section we present how our respondents evaluate their own and their institution's influence on policy-making and, in general, to what extent expertise is influential in Croatian MHP. In addition, this section evaluates how much data on MHP the government gathered, which is a necessary step of evidence-based policy-making and to what extent is knowledge used in Croatian mental health policy in an interdisciplinary way.

Defining Croatian mental health policy

In a form of an open-ended question, participants were asked to describe attitudes of their organization/institution towards mental health as a policy issue. This allowed us to compare views of Croatian institutions with international guidelines, which is highly relevant as all institutions in the sample are policy actors of Croatian MHP. For the analysis of answers to this question, we inductively developed 11 codes that were applied 136 times onto the respondents' answers, which could be divided into three groups presenting three aspects of institutional attitudes.

TABLE 1. Overview of institutional positions on mental health as a question of politics

Aspect of institutional positon	Code	Prevalence
Institutional position on mental health in general	Positive	26.47%
	Negative	25.00%
Institutional position on a key aspect of mental health	Positive mental health	10.29%
	Prevention	8.09%
	Disorder treatment	6.62%
	Awareness	4.41%
	Mental health treatment accessibility	3.68%
Institutional position on mental health goals	Creating mental health policies	5.88%
	Interdisciplinarity	3.68%
	Early influences	2.94%
	Investment	2.94%

Prvo, sudionici su najčešće procjenjivali stavove svoje institucije kao pozitivne ili pak negativne. Od 136 dodijeljenih kodova, pozitivan kod pojavljuje se 36 puta (26,47 %). Kombinira procjene da je stav institucije prema mentalnom zdravlju podržavajući, dobar, aktivan, ohrabrujući, uključen, da je institucija zainteresirana za mentalno zdravlje, da vidi mentalno zdravlje kao važno ili kao prioritet te da je aktivna i poduzima inicijativu. Negativan kod ima sličnu frekvenciju pojavljivanja (25 %), ali raznovrsniji i opsežniji opis. U ovom su kodu institucionalni stavovi označeni kao distancirani, nezainteresirani, neosjetljivi, neinformirani, ravnodušni, nedefinirani, nedovoljni, bez razumijevanja, deklaracijski, neujednačeni, površni, rezignirani, koji zanemaruju kvalitetu, neznalački, ne daju prioritet mentalnom zdravlju, pasivni su, a ponekad i samo nikakvi, nepostojeći.

Druga skupina od 5 kodova pokazuje kako sudionici izražavaju ono što njihova institucija smatra ključnim aspektima mentalnog zdravlja kao pitanja politike. Ti su aspekti: pozitivno mentalno zdravlje s promocijom mentalnog zdravlja (10,29 %), prevencija (8,09 %), tretman poremećaja (6,62 %), podizanje svijesti, uključujući destigmatizaciju, borbu protiv predrasuda, senzibiliziranje javnosti i psihoedukaciju (4,41 %), dostupnost skrbi za mentalno

First, respondents most often evaluated the attitudes of their institution, whether they were positive or negative. Out of 136 times the codes were assigned, the code positive has 36 occurrences (26.47 percent). It combines judgements that the institutional attitude towards mental health is supportive, good, active, encouraging, engaged, that the institution is interested in MH, that it sees MH as important or a priority and that it is active and is taking initiative. Code negative has a similar level of occurrence (25%), but a much more diverse and extensive description. Institutional attitudes in this code are marked as distanced, uninterested, insensitive, uninformed, indifferent, undefined, insufficient, non-understanding, declaratory, uneven, superficial, resigned, disregarding quality, ignorant, non-prioritising MH, passive and sometimes just non-existent.

The second group of 5 codes shows how participants express what their institution sees as crucial aspects of MH as a policy issue. Those aspects are: positive mental health with MH promotion (10.29%); prevention (8.09%); treating disorders (6.62%); raising awareness, including destigmatisation, fighting prejudices, sensitization of the public and psychoeducation (4.41%); and accessibility of mental health care (3.68%). The third group of the last 4 codes

zdravlje (3,68 %). Treća skupina od posljednja 4 koda objašnjava kako su ispitanici opisali neke ciljeve u stavovima svojih institucija o mentalnom zdravlju. Kao cilj naglašavaju utjecaj na stvaranje politike mentalnog zdravlja (5,88 %), interdisciplinarnost navode kao cilj, posebice naglašavajući njezin izostanak (3,68 %), zatim ističu težnju k ranom utjecaju, poput rane prevencije, otkrivanja, rane promocije i rane intervencije (2,94 %), i na posljetku, naglašavaju potrebu većih ulaganja u mentalno zdravlje kao nužnost ili nedostatak tih ulaganja (2,94 %).

Dodatno, kad je zatražen kategorički odgovor na pitanje „U kojoj mjeri se politika mentalnog zdravlja u Hrvatskoj shvaća temom koja nije isključivo dio zdravstvenog sektora već se preklapa s cijelim nizom drugih politika?“, sudionici su odgovorili slično kao i u kvalitativnim odgovorima. Odgovori pokazuju da je u rasponu od 0 do 10 prosječna vrijednost 3,51 (SD = 2,21).

Evaluacija stvaranja politike mentalnog zdravlja u Hrvatskoj danas

Naša se analiza nastavlja fokusom na to kako stručnjaci u hrvatskoj PMZ procjenjuju trenutačno stvaranje ove politike. Od sudionika je zatraženo da izraze svoju razinu pristajanja uz tvrdnju „Prioriteti i sredstva u politici mentalnog zdravlja u Hrvatskoj određuju se na temelju cjelovite slike stanja mentalnog zdravlja i sustavnog pristupa mentalnom zdravlju“. Rezultati su se kretali od 0 do 10, s prosjekom od 2,68 (SD = 2,13).

Višestrukim se izborom ispitanike pitalo i kakvi su njihovi pogledi na najveće izazove i prepreke za razvoj kvalitetne PMZ. Rezultati prikazani na slici 4 pokazuju da su najzastupljeniji odgovori nezainteresiranost političke elite, političara u političkim strankama i političkim institucijama za pitanja mentalnog zdravlja (32,23 % ispitanika) te usko i zastarjelo shvaćanje mentalnog zdravlja (30,58 % ispitanika). Kategorije

explains how respondents described some goals within their institution's attitudes to MH. They stress influencing MH policy-making as a goal (5.88%); interdisciplinarity as a goal, and mostly a lack of it (3.68%); then pursuing early influence such as early prevention, early detection, early promotion and early intervention (2.94%); and finally, a larger investment in MH as a necessity or absence of it (2.94%).

Additionally, when asked to give a categorical answer to a question "To what extent is mental health policy in Croatia perceived as a topic that is not just part of the health sector but overlaps with a whole range of other policies?" the participants' responses were similar to their qualitative answers. The answers show that within the range from 0 to 10 the average value was 3.51 (SD=2.21).

Evaluation of mental health policy-making in Croatia today

Our analysis continues with the focus on how professionals in Croatian MHP evaluate its current policy-making. Participants were asked to give their level of agreement on the statement "Priorities and resources in mental health policy in Croatia are determined on the basis of a complete picture of the state of mental health and a systematic approach to mental health". Results ranged from 0 to 10 and showed the average of 2.68 (SD=2.13).

In the manner of multiple choice, the participants were also asked what their views were on the biggest challenges and obstacles for quality MHP development. The results presented in Figure 4 show that the most prevalent answers are a lack of interest of the political elite – politicians within political parties and political institutions – in the issues of mental health (32.23% of participants) as well as a narrow and outdated understanding of mental health (30.58% of the participants). Categories "insufficient financial resources and investments in the mental health

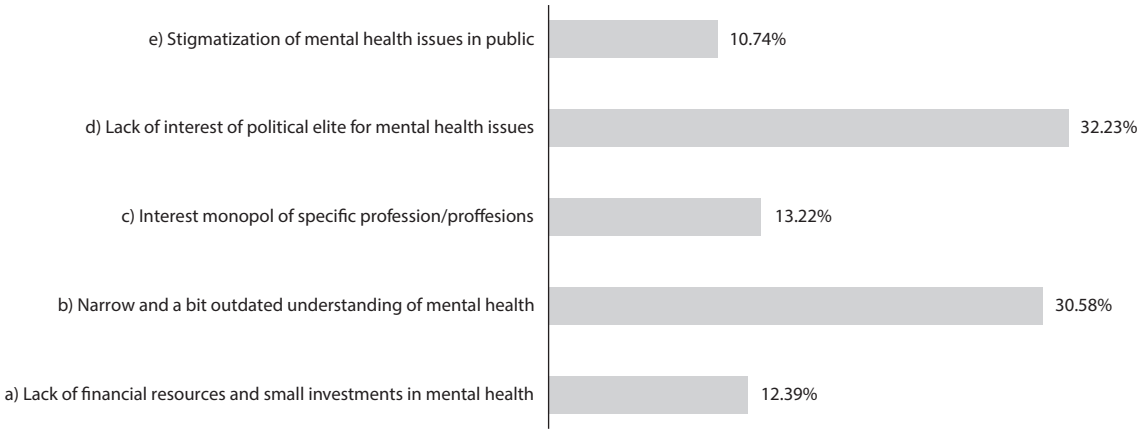

FIGURE 4. Percentage of professionals reporting the issue is the biggest challenge in MHP

„nedostatni financijski resursi i premale investicije u mentalno zdravlje", „interesni monopol pojedine profesije" i „stigmatizacija pitanja mentalnog zdravlja u javnosti", dobili su sličnu učestalost odgovora.

Kod procjenjivanja stavova stručnjaka o implementaciji politike istraživali smo tko su glavni stvaratelji politike, je li pristup politici mentalnog zdravlja organiziran odozgo prema dolje ili odozdo prema gore te kojim se ključnim instrumentima PMZ provodi. Odgovori na šest pitanja iz tablice 2 pokazuju da sudionici većinom nisu sigurni slažu li se s izjavom ili ne, tj. daju prosječne odgovore 'niti se slažem niti se ne slažem' pri čemu je iznimka izjava da se sudionici većinom slažu da PMZ provode gotovo isključivo zdravstvene institucije.

U pitanju otvorenog tipa, sudionici su dali neke prijedloge o tome koje bi mehanizme Vlada trebala intenzivnije koristiti kako bi se stvaranje politike mentalnog zdravlja učinilo uspješnijim. Induktivno smo razvili 15 kodova koji su 183 puta dodijeljeni svim odgovorima na ovo pitanje[5]. Kodovi su podijeljeni u tri skupine preporuka sudionika (tablica 3).

Prvi set preporuka usmjeren je prema instrumentima politike. U teoriji javnih politika,

field", "interest monopoly of one profession" and "stigmatization of mental health in public" received a similar frequency of answers.

When assessing professionals' views on policy implementation, we were interested in finding out who the main policy makers were, whether the approach to MHP is organized top-down or bottom-up and what the key instruments putting the MHP into effect are. The answers to the six questions in Table 2 show that the participants were mostly unsure if they agree with the statement or not, the exception being the statement where participants mostly agree that MHP is almost exclusively implemented by health care institutions.

In an open-ended question, participants gave some proposals as to which mechanisms the government should use more intensively in order to make MH policy-creation more successful. We inductively developed 15 codes, which were assigned 183 times to all the answers to this question.[5] All the codes were divided into three groups of the participants' recommendations (see Table 3).

The first set of recommendations is directed towards policy instruments. In policy theory instruments, governmental tools for achieving pol-

[5] Dodatan rezidualan kod sadrži tri odgovora koji se ne mogu kodirati ("ne znam"; "rad"; "više podrške"), ukupno 1,64 posto od 183 dodijeljena koda.

[5] Additional code is residual, with three non-codable answers ("don't know"; "work"; "more support"), in total 1.64 percent of 183 assigned codes.

TABLE 2. Descriptive results for questions concerning the perception of elements of the implementation of mental health policies (MHP)

	M	SD	Min	Max
MPH are implemented almost exclusively by health care institutions.	3.47	0.95	1	5
MHP include schools, kindergartens, other public sector institutions as well as public and private companies.	2.73	0.95	1	5
MHP is primarily based on hierarchy, clear, precise and strict orders by the appropriate ministry to all subordinate bodies on what to do.	3.15	0.98	1	5
When implementing MHP, the government and the appropriate ministry take into consideration the advice and ideas of other government bodies, agencies, state institutes, public institutions and local governments.	2.55	0.96	1	5
Croatian MHP is implemented primarily through public financing and services in the public sector.	3.34	0.90	1	5
Croatian MHP often uses so-called soft instruments such as public campaigns, information and persuasion, and sometimes standardization and sanctions.	2.97	0.80	1	5

Legend: M – arithmetic mean, SD – standard deviation, min – minimal result, max – maximal result

TABLE 3. Overview of recommendations for the improvement in the creation of Croatian mental health policies (MHP)

Recommendations	Code	Prevalence
For policy instruments	Information technology instruments	13.11%
	Financial instruments	7.65%
	Organizational instruments	5.46%
	Legal instruments	2.73%
For developing key aspects of MHP	Holistic mental health	13.66%
	Accessibility	3.83%
	Early influence	2.19%
For creating policies	Expertise	10.38%
	Interdisciplinarity	10.38%
	Networking	7.1%
	Evidence-based policies	6.56%
	Strategic planning	4.92%
	Multi-sectoral approach	4.92%
	Implementation	3.83%
	Political will	1.64%

instrumenti, alati države za postizanje ciljeva neke politike, obično se klasificiraju u četiri kategorije: financijski instrumenti (oporezivanje i trošenje proračunskih sredstava), organizacijski instrumenti (formiranje državnih tijela i njihov rad), pravni instrumenti (sve vrste regulative) i informacijski instrumenti (prikupljanje podataka ili distribuiranje podataka od Vlade) (35). Svi tipovi instrumenata pojavili su se u odgovorima ispitanika: informacije, uključujući

icy goals are usually classified into four categories: financial instruments (taxation and budget spending), organizational instruments (governmental bodies' formation and performance), legal instruments (all kinds of regulation), and information instruments (data collecting or data releasing performed by the government) (35). All types of instruments appeared in the answers of the respondents: information, including public campaigns, education, workshops and commu-

javne kampanje, edukacije, radionice i komunikacija općenito (13,11 %); financije uključujući fondove EU-a, financiranje stručnjaka, nevladinih organizacija, programate ulaganja općenito (7,65 %); organizacija, uključujući osnivanje glavnog tijela za koordinaciju, reformiranje i restrukturiranje sustava, decentralizaciju, poboljšanje bolničkih kapaciteta i zapošljavanja (5,46 %) i donošenje nove regulative (2,73 %).

Druga skupina od tri koda naglašava aspekte PMZ-a koje sudionici istraživanja vide kao ključne za razvoj politike. To su: holističko, široko razumijevanje mentalnog zdravlja, uključujući prevenciju, promociju, destigmatizaciju, povećanje svijesti i senzibiliziranje (13,66 %); dostupnost tretmana, usluga i zaposlenja (3,83 %); i rani utjecaj, određivanje djece i mladih kao primarne ciljne skupine (2,19 %). Treća najveća skupina s preostalih 8 kodova opisuje preporuke sudionika za stvaranje politike. Najčešći se odgovori odnose na općenite prijedloge da se uključi više stručnog znanja u stvaranje politike (10,38 %) i više interdisciplinarnosti ili multidisciplinarnosti (10,38 %). Osim toga, sudionici preporučuju više umrežavanja što znači suradnju svih aktera, uključivanje različitih dionika, osobito nevladinih organizacija (7,1 %). Bilo je također nekih prijedloga za veću učestalost stvaranja politike utemeljene na dokazima (6,56 %), više strateškog planiranja u hrvatskoj PMZ (4,92 %), za kretanje prema multisektorskoj politici (4,92 %) i za bolju implementaciju i kontrolu postojeće politike (3,83 %). Naglašavanje političke volje kao ključnog pokretača promjene dobilo je najniži rezultat (1,64 %).

Uloga ekspertize u kreiranju politike mentalnog zdravlja

Kako bismo razumjeli kako se ekspertiza doista koristi u stvaranju PMZ-a u Hrvatskoj, zatražili smo od sudionika da opišu ulogu svoje organizacije kao i svoju osobnu ulogu u PMZ-u. Opisi organizacijskih i osobnih udjela u razvoju

nication in general (13.11%); finance, including EU funds, financing of experts, NGOs, programs and investment in general (7.65%); organization, including the establishment of the main coordination body, reforming and restructuring, decentralisation, improving hospital capacities and employment (5.46 percent); and producing new regulation (2.73%).

The second group of three codes stresses aspects of MHP that study participants see as fundamental for policy development. Those are: a holistic, broad understanding of MH, including prevention, promotion, destigmatisation, raising awareness and sensitization (13.66%); accessibility of treatment, services and employment (3.83%); and early influence, setting children and youth as the primary target group (2.19%). The third group, the biggest one with the remaining 8 codes, describes the participants' recommendations for policy-making. Most frequently, the answers contain general suggestions to include more expertise in policy-making (10.38%) and to include more interdisciplinarity or multidisciplinarity (10.38%). In addition, participants recommend more networking, including cooperation of all actors, the inclusion of different stakeholders, especially NGOs (7.1%). There have also been some suggestions for more evidence-based policy-making (6.56%), more strategic planning in Croatian MHP (4.92%), changes towards multi-sectoral policy (4.92%) and a better implementation and control of existing policy (3.83%). Stressing the political will as crucial driver of change received the lowest scores (1.64%).

The role of expertise in mental health policy-making

In order to grasp the way expertise is actually being used in the creation of MHP in Croatia, we asked the participants to describe their organization's role and their personal role in MHP. The descriptions of organizational and personal

PMZ-a pokazali su veliku raznolikost aktivnosti organizacija i samih stručnjaka. Indukcijski smo razvili 11 kodova za uloge u PMZ-u koji su 166 puta pripisani odgovorima za organizacijsku razinu i 180 puta odgovorima na individualnoj razini (tablica 4). Posebna je pažnja obraćena sudjelovanju ispitanika u stručnim radnim skupinama.

Stručnjaci iz različitih institucija mentalnog zdravlja u Hrvatskoj opisali su 11 uloga koje njihova organizacija obavlja u utjecanju na PMZ. Najvažnija među njima je tretman (uključujući savjetovanje i psihoterapiju) koji je kao kod dodijeljen 30 puta od ukupno 166 (18,07 %). Slijede ga edukacija (13,86 %), razvoj i implementacija programa i projekata (10,84 %) i preventivne aktivnosti (9,64 %). Svi navedeni načini utjecanja institucija na politiku mentalnog zdravlja odnose se na praktični rad i intervencije u mentalnom zdravlju. Ukupno čine više od polovice svih pripisanih kodova (52,41 %), iako je to tek 4 od 11 kodova razvijenih za ovo pitanje.

Aktivnosti koje su izravnije obraćene stvaranju politike također su prisutne, ali se puno rjeđe pojavljuju u odgovorima sudionika. Te su aktivnosti: zagovaranje politike i senzibiliziranje javnosti, uključujući podizanje svijesti, destig-

partaking in MHP development showed great variability of activities between organizations and professionals themselves. We inductively developed 11 codes of roles in MHP, which were assigned 166 times on the answers for the organizational level and 180 times on the answers for the individual level (Table 4). Special attention was given to the participation of survey respondents in expert working groups.

Professionals from diverse MH institutions in Croatia described 11 roles their organization takes in influencing MHP. The most important of these is treatment (including counselling and psychotherapy), which as a code was assigned 30 times out of 166 (18.07%). It is followed by education (13.86%), developing and implementing programs and projects (10.84%) and prevention activities (9.64%). All these ways of influencing MHP by institutions are connected to practical work, to MH interventions. When combined, they consume more than a half of all assigned codes (52.41%), even though these are only 4 out of 11 codes developed for this question.

Activities that are more directly devoted to policy-making are also present, but with much lower frequencies of occurrence in survey participants' answers. Those activities are: advocacy and sensitization of the public, including raising

TABLE 4. Overview of institutional and individual roles in the creation of Croatian mental health policies

Role/code	Prevalence at the institutional level	Role/code	Prevalence at the individual level
Treatment	18.07%	Treatment	18.89%
Education	13.86%	Advocacy and awareness	14.44%
Nothing	12.65%	Education	13.33%
Programs and projects	10.84%	Membership	9.44%
Prevention	9.64%	Nothing	8.89%
Advocacy and awareness	7.83%	Prevention	8.33%
Membership	6.63%	Conferences	7.78%
Policy design	5.42%	Programs and projects	6.11%
Research	5.42%	Research	5.56%
Conferences	5.42%	Cooperation	2.78%
Cooperation	4.22%	Policy design	2.78%

matizaciju i javne debate (7,83 %); članstvo u vladinim tijelima, ministarskim odborima, udruženjima i na sastancima stručnjaka (6,63 %); oblikovanje politike razvojem prijedloga, strategija, nove regulative, izvještaja, itd. (5,42 %); te suradnja s drugim akterima, s nevladinim organizacijama, također i na međunarodnoj razini (4,22 %). Sve aktivnosti stvaranja politike zajedno pojavljuju se u odgovorima sudionika 24,1 posto vremena. Zadnje dvije aktivnosti koje potpadaju negdje između intervencija u području mentalnog zdravlja i stvaranja politike jesu istraživanje, uključujući diseminaciju nalaza (5,42 %) i organiziranje konferencija, okruglih stolova i radionica (5,42 %). Kod „ništa" kojim se izriče da institucija ispitanika nema nikakvu ulogu u razvoju PMZ-a dobio je prilično visok rezultat – 12,65 %.

Vlastitu ulogu u kreiranju politike u području mentalnog zdravlja, prema frekvenciji pojavljivanja, stručnjaci su opisali na sljedeći način: tretman (18,89 %), zagovaranje i senzibiliziranje (14,44 %), edukacija (13,33 %), članstvo (9,44 %), ništa (8,89 %), prevencija (8,33 %), konferencije, većinom organiziranje i vođenje radionica (7,78 %), programi i projekti (6,11 %), istraživanje (5,56 %), suradnja i dizajnpolitike (oboje po 2,78 %)[6]. Kodovi povezaniji sa stvaranjem politike, zagovaranje i senzibiliziranje, članstvo, suradnja i dizajn politike zajedno, češće su se pojavljivali na osobnoj nego na institucionalnoj razini (29,44 %).

Istraživali smo i sudjelovanje naših ispitanika u stručnim radnim skupinama, što je uži termin od sadržaja koda „članstvo", budući da stručne radne skupine čine jedan od najvažnijih načina da se više znanja uključi u stvaranje politike. Nikada nije bilo uključeno ni u jednu vrstu stručne radne skupine74,8 % sudionika. Tek je 30 sudionika od 121 ispitanog član neke

awareness, destigmatization and public debates (7.83%); membership in governmental bodies, ministerial committees, professional associations and expert meetings (6.63%); policy design as development of policy proposals, strategies, new regulation, reports, etc. (5.42%); and cooperation with other actors, with NGOs, and on an international level (4.22%). All policy-making activities together occurred 24.1 percent times in the respondents' answers. The last two activities that fall somewhere in between MH interventions and policy-making are research, including research dissemination (5.42%) and organizing conferences, round tables and workshops (5.42%). The code "no-way", declaring that the institution has no role in developing MHP, scored quite highly – 12.65 percent.

This is how professionals in our survey described their own role in MH policy-making, by the frequencies of occurrence: treatment (18.89%); advocacy and sensitization (14.44%); education (13.33%); membership (9.44%); no-way (8.89%); prevention (8.33%); conferences, mostly organizing and leading workshops (7.78%); programs and projects (6.11%); research (5.56%); cooperation and policy design (both 2.78%).[6] Codes more connected to policy-making, advocacy and sensitization, membership, cooperation and policy design together occurred more frequently on a personal than an institutional level (29.44%).

We further explored the participation of our respondents in expert working groups, a narrower term than the content of code "membership", as they are one of the crucial ways of including more knowledge into policy-making. 74.8% of participants were never included in any kind of expert working group. Only 30 of 121 people assessed with our questionnaire were members of any MHP expert group. When the position

[6] Rezidualni kod ovdje je dobio 1,67 posto, s tri odgovora koja se nisu mogli kodirati ("ne znam"; "nastojim dati pojedine savjete ", "aktivnim sudjelovanjem u organiziranju pojedinih događaja u bolnici").

[6] Code residual here received 1.67 percent, with three answers that were not codable ("don't know"; "by giving advice", "I organize events in my hospital").

stručne skupine iz područja politike mentalnog zdravlja. Uzmu li se u obzir položaj i važnost funkcije u instituciji nalazimo da je tek 13 od tih 30 sudionika uključenih stručne radne grupe zauzimalo vodeće i odgovorne položaje, kao što su voditelji odjela ili institucija. Drugih 17 sudionika bili su zaposlenici.

Članstvo u stručnim skupinama varira. Sudionici su uključeni u lokalne i nacionalne stručne skupine; u ministarska povjerenstva za razvoj zakonodavstva (obrazovanje, psihoterapija, zaštita zdravlja) ili pak ona specijalizirana za psihijatriju; u povjerenstva za nacionalne strategije za djecu i mlade; u povjerenstvo za zaštitu mentalnog zdravlja; u radne skupine za reformu psihijatrijskih usluga; u stručne skupine za razvoj strategije prevencije ovisnosti kao i za različite protokole (prevenciju suicida, prevenciju nasilja, tretman zloporabe narkotika, itd.).

Tip i utjecaj znanja u kreiranju politike mentalnog zdravlja u Hrvatskoj

Sudionike smo zamolili da procijene razinu utjecaja svoje institucije na razvoj politike mentalnog zdravlja, razinu svog osobnog utjecaja, općeniti utjecaj ekspertize i znanja na donošenje ove politike, kao i razinu vladine posvećenosti trajnom prikupljanju podataka o provođenju politike mentalnog zdravlja. Također smo zamolili sudionike da procijene koliko je znanje korišteno u razvoju politike mentalnog zdravlja interdisciplinarno. Mogući odgovori kretali su se od nula (gotovo bez utjecaja, nikada ili ništa) do deset (iznimno značajan utjecaj, često ili posve).

Rezultati u tablici 5 upućuju na to da sudionici našeg istraživanja općenito vide malo mogućnosti za utjecaj na razvoj hrvatske politike mentalnog zdravlja, budući da su svi rezultati ispod statističkog prosjeka. Najniži su odgovori na pitanja o njihovom osobnom utjecaju i doživljaju da se stručnost i znanje cijene. Utjecaj

and importance of function in an institution was taken into account, we found that only 13 from those 30 participants included in expert groups occupied a position of leadership and responsibility, being heads of their department or leading the institution in question. Other 17 participants were employees.

Expert group membership varied a lot. Participants were involved in local and national expert groups; ministry committees for law development (education, psychotherapy, health protection) or those specialized for Croatian psychiatry; the committee for national strategies for children and youth; the committee for mental health protection; the reform group of psychiatric services; the expert group for drug prevention strategy as well as for various protocols (for suicide prevention, aggression prevention, substance abuse treatment, etc).

Type and influence of knowledge in Croatian MH policy-making

Finally, participants were asked to evaluate the level of their institution's influence on MHP development, the level of their personal influence, the general influence of expertise and knowledge on policy-making, as well as the level of governmental commitment to continuous data-collection on MHP implementation. We also asked participants to estimate to what extent the knowledge used in MHP development is interdisciplinary. Possible answers ranged from zero (almost no influence, never or none) to ten (extremely significant influence, often or completely).

The results in Table 5 indicate that study participants in general perceive little possibility for influencing Croatian MHP development, all results being lower than the statistical average. The lowest answers are given for their personal influence and the perception that expertise and knowledge are appreciated. Institutions are seen as having an impact, which is slightly better. Additionally, participants were asked if

TABLE 5. Descriptive results for questions concerning the influences on the creation process for mental health policies

	M	SD	min	Max
How would you characterize the influence of your organization/institution on the decision-making process in Croatian mental health policies?	3.58	2.73	0	10
How would you characterize your personal influence on the decision-making process in Croatian mental health policies?	2.89	2.45	0	9
To your knowledge, how much do the relevant governmental bodies rely on expertise and knowledge in the development for Croatian mental health policies?	3.04	1.84	0	7
To what extent is the knowledge used in the development of Croatian mental health policies interdisciplinary?	3.57	2.08	0	10
Governmental bodies continuously gather data on all activities in the process of implementing mental health policies.	3.17	1.99	0	10

Legend: M – arithmetic mean, SD – standard deviation, min – minimal result, max – maximal result

institucija procijenjen je kao nešto bolji. Osim toga, sudionici su odgovarali na pitanje prikupljaju li vlasti kontinuirano podatke o svim aktivnostima u procesu implementacije politike mentalnog zdravlja, a prosječan rezultat u rasponu od 0 do 10 je 3,14 (SD=1,99).

Budući da su psihijatri i psiholozi najzastupljeniji stručnjaci u našem uzorku, provjerili smo percepcije utjecaja ovih dviju profesija. Rezultati međugrupnih razlika prikazani su u tablici 6. Razlike u percepciji utjecaja na razvoj politike mentalnog zdravlja između psihijatara i psihologa nisu statistički značajne iako je u odgovorima zabilježena određena tendencija. To što rezultat nije značajan mogla bi biti posljedica malog broja ispitanika u svakoj skupini.

authorities continuously collect data on all activities in the process of MHP implementation and it was found that the average result in the range from 0 to 10 is 3.14 (SD=1.99).

Since psychiatrists and psychologists are professionals with the biggest representation in our sample, we checked perceptions of influence coming from these two professions. The results of mean differences are seen in Table 6 below. The differences in perception of influence on MHP development between psychiatrists and psychologists are not statistically significant, although there was some tendency in the answers. The non-significant result could be the consequence of a small number of participants in each group.

TABLE 6. Differences in the perception of influences on the process of mental health policy (MHP) creation between psychiatrists and psychologists

Development of Croatian mental health policy	M	SD	t-test
Influence of the organization/institution on the decision-making process			
Psychiatrists	3.77	2.95	t=1.58
Psychologists	2.74	2.54	(df=64; p>.05)
Personal influence on the decision-making process			
Psychiatrists	2.73	2.45	t=0.20
Psychologists	2.74	2.56	(df=66. p>.05)
The government relies on expertise and knowledge			
Psychiatrists	2.65	1.78	t=-1.61
Psychologists	3.42	2.16	(df=66. p>.05)
Interdisciplinary use of knowledge			
Psychiatrists	2.95	1.76	t=-1.86
Psychologists	3.90	2.45	(df=66. p>.05)
Continuous monitoring of MHP implementation			
Psychiatrists	3.03	2.41	t=-0.47
Psychologists	3.26	1.73	(df=66. p>.05)

Legend: M – arithmetic mean, SD – standard deviation, t – t-test, df – degree of freedom, p – level of significance

RASPRAVA

Naše je istraživanje procijenilo subjektivnu percepciju razvoja i ekspertize hrvatske PMZ te subjektivne poglede sudionika na njihovo radno mjesto i njegov utjecaj te na aktivnosti u PMZ općenito. Treba naglasiti da su sudionici studije vrlo heterogeni, neki od njih uključeni su u razvoj PMZ-a, ali nisu nužno obrazovani u tom polju, a drugi su tek stručnjaci koji rade u različitim sektorima u području skrbi za mentalno zdravlje i nikad ne sudjeluju u stručnim radnim skupinama ili drugim aspektima stvaranja politike. Pa ipak, percepcije različitih stručnjaka iz sustava omogućuju širu i bogatiju sliku ovog pitanja, budući da sudionici koji nisu uključeni u stvaranje politike uravnotežuju potencijalna pozitivna pretjerivanja u procjeni onih koji vjeruju da je njihov utjecaj značajan.

Ranija su istraživanja pokazala da je suvremena politika mentalnog zdravlja, onakva kako je zastupljena u međunarodnim dokumentima i na razini Europe, multisektorska (2-4). U svrhu diskutiranja nalaza o definiciji i sadržaju PMZ-a u Hrvatskoj mogli bismo poći od shvaćanja da, iako su u podatcima jednako prisutne i pozitivne i negativne procjene institucijskih stavova prema mentalnom zdravlju, visoka prisutnost negativne procjene je ozbiljan razlog za zabrinutost. Budući da su sve institucije uključene u studiju akteri hrvatske PMZ, takva percepcija ograničava potencijal za promjenu i kvalitetan razvoj PMZ-a. Pozitivno je to što se čini da hrvatska PMZ koja se odražava u institucijskim stavovima o mentalnom zdravlju, naginje k modernom sadržaju zagovaranom na globalnoj razini. Prisutna su sva ključna područja PMZ-a.

Međutim, aspekti socijalne politike i ljudskih prava i dalje su zanemareni, budući da je njihov sadržaj prilično uzak. U području ljudskih prava temeljna pitanja dostojanstva i uključenosti osoba s mentalnim poremećajima potpuno su izostala, a druge socijalne usluge, osim skrbi o mentalnom zdravlju, uopće nisu zastupljene.

DISCUSSION

Our research assessed the participants' subjective perception of Croatian MHP development and expertise, as well as the participants' subjective views upon their workplace, its influence and activities within MHP in general. It should be stressed that study participants are very heterogeneous, some of them involved in MHP development, but not necessarily educated in this field, and others just professionals working in different sectors of the mental health care field and are never included in expert working groups or other aspects of policy-making. Still, perceptions of diverse professionals from the system ensure a broader, richer picture of the issue at stake, as participants not involved in policy-making balance potential positive exaggerations in evaluation of those who believe that they are making a difference.

Previous research has shown that contemporary mental health policy, as advocated in international documents and on the European level, is a multi-sectoral policy (2-4). For the purpose of commenting on our findings regarding the MHP definition and content in Croatia, we could start with the notion that even though positive and negative evaluation of institutional attitudes towards MH are equally present in the data, a high presence of negative evaluation poses serious concerns. As institutions included in this study are all actors of Croatian MHP, this perception limits the change potential and quality MHP development. On the positive side, it seems that Croatian MHP, reflected in institutional views on MH, is inclining towards its modern and globally advocated content. All key areas of MHP are present.

However, social policies and human rights aspects are still neglected, as their content is quite narrow. In the field of human rights, fundamental issues of dignity and inclusion of people with mental disorders are completely absent, and all other social services, except

Ovo je djelomično rezultat pristranosti u uzorkovanju ponajprije institucija iz zdravstvenog sektora. Nadalje su sudionici odgovarali slično na kategorijska pitanja kao i u kvalitativnim odgovorima. Podatci pokazuju da sudionici smatraju kako politika mentalnog zdravlja u Hrvatskoj pripada u prvom redu zdravstvenom sektoru, da nije dio multisektorskog pristupa, pa je stoga kategorijsko pitanje o njezinoj povezanosti i prirodnom preklapanju s nizom drugih politika također dobio poražavajuće rezultate: odgovori pokazuju da je u rasponu od 0 do 10 prosječna vrijednost 3,51 (SD=2,21).

U diskusiji o stvaranju politike mentalnog zdravlja u Hrvatskoj rezultati pokazuju da sudionici naše studije naglašavaju da ono nije sustavno. Upitani o implementaciji, sudionici proces donošenja odluka opisuju kao problematičan, a za državne prioritete i raspodjelu sredstava kažu kako nisu utemeljeni na cjelokupnoj slici stanja mentalnog zdravlja. Rezultati idu u prilog isključivoj prisutnosti zdravstvenih institucija u stvaranju politike, hijerarhijskom donošenju odlukaodozgo prema dolje, nalozima nadležnog ministarstva podređenim institucijama i provođenju politike javnim sredstvima i uslugama javnog sektora. Konzultiranje s drugim državnim akterima, agencijama, javnim institucijama i lokalnim vlastima procijenjeno je kao manje razvijen način stvaranja politike. Kao ključne prepreke poboljšanju stanja sudionici posebno naglašavaju nedostatak političke volje u pitanjima mentalnog zdravlja te usko i zastarjelo shvaćanje mentalnog zdravlja. Sveukupno, odgovori koji odražavaju percepciju o stvaranju politike upućuju na to da ga stručnjaci u sektoru ocjenjuju kao nekvalitetno, nesistematično, temeljeno na zastarjelim shvaćanjima mentalnog zdravlja, jako ovisno o glavnim državnim tijelima kojima upravlja politička elita izrazito nezainteresirana za mentalno zdravlje.

Očito je da stručnjaci u području mentalnog zdravlja u Hrvatskoj o unaprjeđenju PMZ-a razmišljaju u skladu s međunarodnim smjernimental health care, are not present. This is partially biased by the sampling of institutions dominantly from the health sector. Additionally, participants reported similarly on categorical questions as in qualitative answers. The data showed that they believe that mental health policy in Croatia is seen mainly as a part of the health sector, without a multi-sectoral approach, i.e., its connections and a natural overlap with a range of other policies, as the categorical question also received devastating scores: answers show that within the range of 0 to 10, the average value was 3.51 (SD=2.21).

When commenting on MH policy-making in Croatia, the results show that participants of our study stress that it is not systematic. When asked about the implementation, the participants see the decision-making process as problematic, and state priorities and resource distribution as not actually based upon a complete picture of the state of mental health. The results are more in favour of exclusivity of health care institutions in policy-making, hierarchical top-down decision-making, the ordering of competent ministry to subordinate institutions and conduction of policy through public funding and the services of the public sector. Consulting other state actors, agencies, public institutions and local authorities was seen as a less developed policy-making mode. As key obstacles to the improvement of detected status, participants specifically stress the lack of political will in the issues of MH and a narrow and outdated understanding of MH. In total, answers reflecting the perception of policy-making indicate that professionals in the MH sector evaluate Croatian policy-making in the field to be of poor quality, unsystematic, based on outdated views on MH and highly dependent on top governmental bodies that are run by the political elite intensely uninterested in MH.

It is obvious that MH professionals in Croatia think about improvement of MHP in line with international guidelines. They stress a broad

cama. Naglašavaju široko i holističko razumijevanje mentalnog zdravlja kao bazu za razvoj PMZ-a, koji bi trebao biti unaprijeđen prije svega višom razinom upotrebe interdisciplinskog znanja, sudjelovanjem različitih dionika, utemeljenošću na dokazima i *soft* instrumentima utemeljenima na informacijama. Ipak, u kvalitativnim odgovorima sudionika politička volja, na koju je stavljen naglasak kao na glavnu prepreku razvoju PMZ-a, nije dovoljno prepoznata kao nužan faktor promjene. Osim toga, aktivnosti zagovaranja politike od stručnjaka i profesionalaca te odnos političke elite i stručnjaka nisu uočeni kao važan poticaj razvoju hrvatske PMZ. Sudjelovanje u stvaranju politike treba biti puno prisutniji cilj u perspektivi aktera, ako očekujemo više ekspertize, korištenja znanja i promjena u kvaliteti hrvatske PMZ.

To nas vodi mnogostrukim ulogama koje institucije i pojedinačni stručnjaci igraju u donošenju hrvatske PMZ. Moramo zaključiti kako prema opažanjima naših sudionika, institucije i organizacije mentalnog zdravlja u Hrvatskoj u promicanju PMZ-a sudjeluju i dalje tek sporadično i djelomično. A one su vrlo značajni akteri politike u ovom polju i trebale bi biti ključni nositelji znanja u sektoru. Iako su institucije i organizacije, a ne pojedinci, primarni akteri stvaranja politika, naše smo sudionike pitali i o njihovoj ulozi u razvoju PMZ-a. Razlog tomu jest činjenica da pojedinac u stvaranju politika može preuzeti ulogu poduzetnika javnih politika, koji kao osobito utjecajna osoba ili predstavnik neke organizacije može potaknuti otvaranje prilike za promjenu politike (35). Naša analiza pokazuje da se kodovi povezani sa stvaranjem politike pojavljuju nešto češće na osobnoj nego na institucijskoj razini. Međutim, takav je rezultat donekle varljiv. Budući da su smisao i značenje kodova kod kvalitativnih podataka relevantniji od frekvencije, valja nam pogledati u same kodove. Kod zagovaranje i senzibiliziranje ima visoku učestalost jer su sudionici često spominjali promociju mentalnog

and holistic understanding of MH as a basis for MHP development, which should be forwarded primarily by the higher level of usage of interdisciplinary knowledge, the participation of diverse stakeholders, evidence-based policy-making and a soft instrument based on information. Still, political will stressed as a prime obstacle of MHP development was poorly recognized as the necessary factor of change in the respondents' qualitative answers. Additionally, policy advocacy activities of experts and professionals and relationships between the political elite and experts did not come up as important drivers of developing Croatian MHP. The goal of participating in policy-making should be much more dominant in the actors' perspectives if we are to expect more expertise, knowledge-usage and quality changes in Croatian MHP.

This leads us to diverse roles institutions and professional individuals play in policy-making of Croatian MHP. We must conclude that, according to the perception of our respondents, MH institutions and organizations in Croatia still sporadically and partially participate in advancing MHP. They represent highly relevant policy actors in this field and should be the crucial carriers of knowledge within the sector. Even though institutions and organizations, and not individuals, are primary actors of policy-making, we have also asked participants of our survey about their own role in MHP development. Since in policy-making a single person, a special individual or representative of some organization, can take over the role of a policy entrepreneur, individual influence can serve to open the window of opportunity for policy change (35). Our analysis shows that codes more connected to policy-making occur slightly more frequently on the personal than on the institutional level.

However, this result is slightly deceiving. Since with qualitative data, content and meaning of codes are more relevant than the frequency, we need to look inside the codes. Advocacy

zdravlja, ali uglavnom na individualnoj razini ili unutar njihove institucije (npr. pacijentima, obiteljima pacijenata ili nadređenima), a ne na razini države. Osim toga, ključne aktivnosti stvaranja politike, dizajniranje politike razvijanjem strateških smjernica te formiranje zagovaračkih koalicija u suradnji s raznovrsnim akterima gotovo da su izostali iz podataka o osobnom angažmanu. Destimulaciju poduzetnika javnih politika dobro opisuje sljedeći navod. „Pokušavam ukazivati na razne probleme, kako pojedinca koji mi je u tretmanu, tako i sustava, pogotovo kada sustav loše utječe na pojedinca i na njegovo mentalno zdravlje, no najčešće dobijem "po prstima" da bi mi bilo pametnije da šutim i da radim svoj posao jer ako nešto prijavim i/ili javno kažem, moglo bi se otkriti kako neki drugi u tom sustavu ne rade". Uz to, naši su sudionici rijetko uključeni u stručne radne skupine. Iako su teme o uključivanju sudionika istraživanja u savjetovanje o politici različite, izravan utjecaj institucijskih aktera i pojedinaca-stručnjaka na aktivnosti stvaranja politike i dalje je razočaravajuće nizak.

Zaključit ćemo s komentarima na odgovore o tipu znanja i njegovu utjecaju na stvaranje hrvatske politike mentalnog zdravlja, iz perspektive sudionika naše studije. Najniži su rezultati kod odgovora na pitanja o osobnom utjecaju sudionika i doživljaju da se ekspertiza i znanje cijene. Utjecaj institucija procijenjen je kao nešto bolji iako ga se ne može smatrati značajnim. Usporedimo li dvije najutjecajnije skupine, psihologe i psihijatre, čini se da psihijatri svoje institucije percipiraju utjecajnijima, dok psiholozi izvještavaju o ponešto većoj upotrebi ekspertize i znanja u razvoju PMZ-a te o većoj interdisciplinarnosti nego što to čine psihijatri. Većina psihijatara radi u psihijatrijskim ustanovama, a poslodavci psihologa su raznovrsniji. Subjektivna percepcija psihijatara da tradicionalne psihijatrijske ustanove imaju više utjecaja nego druge ustanove u kojima rade psiholozi, u hrvatskim se prilikama može činiti prilično

and sensitization received a high occurrence as respondents often mentioned the promotion of mental health, but mostly on the individual level or within their institution (e.g. to patients, to patients' families, to superiors), and not on the national level. Additionally, crucial policy-making activities, designing policy change by developing strategic guidelines and forming advocacy coalitions in cooperation with diverse actors, were almost absent from the data for individual-level engagement. The discouragement of policy entrepreneurship is nicely described by the following quote. "I am trying to point to specific individual problems of users or to problems in the system, but it goes down in flames. I get the message that it is better to stay quiet since my open remarks could point to flaws and lack of work done by others". Additionally, our respondents were rarely included into expert working groups. Even though topics on inclusion of survey participants in policy advising are diverse, direct influence on policy-making activities of institutional actors and of individual professionals still seems to be disappointingly low.

We will conclude with the comments on answers about the type and influence of knowledge in Croatian MH policy-making from the perspective of our study participants. The lowest answers were given for their personal influence and the perception that expertise and knowledge are appreciated. It is seen that institutions have a slightly better impact, although it cannot be concluded that this impact is influential. If we compare two of the most influential groups, psychologists and psychiatrists, it seems that psychiatrists perceive their institutions as more influential, while psychologists report slightly more use of expertise and knowledge in MHP development, as well as more interdisciplinarity than psychiatrists do. Most psychiatrists work in psychiatric institutions while psychologists' employers are more diverse. Psychiatrists' subjective perception

realnom. Istovremeno, psihijatri manje izvještavaju o interdisciplinarnosti i uporabi stručnog znanja u PMZ-u, što može upućivati na to da više oklijevaju i osjećaju se nemoćnijima u velikom sustavu, međutim to zahtijeva daljnje istraživanje. Ipak, za obje struke, rezultati nisu ni približni prosjeku navedene ljestvice pa možemo primijetiti da se obje skupine stručnjaka slažu utoliko što percipiraju malo mogućnosti za utjecaj.

ZAKLJUČAK

Kako je u ovoj studiji korišten upitnik samoprocjene, dobiveni odgovori obilježeni su subjektivnim doživljajem sudionika, stručnjaka iz sustava skrbi za mentalno zdravlje. Nažalost, podatke za neke objektivnije mjere stvaranja politike mentalnog zdravlja nismo bili u mogućnosti prikupiti. Jedan od glavnih problema ove studije jest kvaliteta upotrijebljenog upitnika koji je konstruiran za procjenu stavova te prethodno nije validiran ili standardiziran. Neke od čestica su direktivne pa bi budući rad trebao stremiti k razvoju boljih mjera. Analiza uzorka pokazuje da su sudionici došli iz različitih sektora i ta je različitost vrlo očita: različito doživljavaju mentalno zdravlje i imaju različite perspektive. Buduća bi istraživanja trebala obuhvatiti i te različitosti između sektora. Usprkos tome, čak i s ovim ograničenjima prikupljeni podatci pružaju nam neke uvide koji su u skladu s istraživačkom svrhom ovoga rada.

Rad smo započeli normativnim argumentom da bi proces stvaranja politika mogao biti kvalitetniji, uspješniji i učinkovitiji kad bi uključivao intenzivniju uporabu znanja. Stanje hrvatske politike mentalnog zdravlja u skladu je s tom pretpostavkom budući da je naša analiza pokazala kako stručnjaci stvaranje politike doživljavaju prilično nekvalitetnim i imaju dojam izuzetno slabe uporabe znanja u tom sektoru. Kvalitativni i kvantitativni podatci iz naše studije upućuju na to da su multisektorski pristup

that traditional psychiatric institutions have more impact than other institutions where psychologists might work seems quite realistic for Croatian circumstances. At the same time, lower reports on interdisciplinarity and usage of expertise in MHP coming from psychiatrists may indicate that they feel more reluctant and powerless within the big system but that calls for future research. Nevertheless, for both professions the results are not even close to the average of the given scale, so we can note that both groups of experts agree, since they perceive little possibility of influence.

CONCLUSION

The assessment in this study is conducted by a self-report questionnaire that reflects subjective perceptions of the participants, professionals in the mental health care system. Unfortunately, we were not able to collect data for some more objective measurements of mental health policy-making. One of the main problems of this study is the quality of the questionnaire used – it was designed to assess attitudes and it was not evaluated or standardized beforehand. Some of the items are directive, so future work should be directed towards the development of better measures. Sample analysis shows that participants came from different sectors and it is evident that those sectors differ: they perceive mental health differently and have different perspectives. Future research should cover those differences between the sectors. Nevertheless, even with these limitations, the collected data provided some insights in line with the exploratory purpose of the paper.

Our paper started with the normative argument that the policy-making process could be of higher quality, more successful, efficient and effective if the usage of knowledge in that process was more intense. The state of Croatian mental health policy is coherent with this assumption, as our analysis showed the pro-

i interdisciplinarnost znanja u hrvatskom kontekstu vrlo slabo zastupljeni što pokazuje da je holistička politika mentalnog zdravlja još uvijek u fazi postavljanja na dnevni red što je prvi korak razvojnog ciklusa stvaranja politike. Možemo zaključiti da stručnjaci iz sektora mentalnog znanja stvaranje politike u tom polju procjenjuju kao nesistematično i utemeljeno na zastarjelim stavovima o mentalnom zdravlju, iznimno ovisno o najvišim tijelima vlasti, kojima upravlja politička elita većinom nezainteresirana za mentalno zdravlje.

Prema našoj studiji, profesionalci i stručnjaci poboljšanje PMZ-a zamišljaju u skladu s međunarodnim smjernicama. Naglašavaju široko i holističko razumijevanje mentalnog zdravlja kao temelja za razvoj PMZ-a. Istovremeno, podatci pokazuju da stručnjaci iz područja mentalnog zdravlja rijetko sebe uzimaju u obzir kao aktivne sudionike u procesu stvaranja politike. Češće izvješćuju o svom praktičnom radu i intervencijama prema korisnicima te se općenito osjećaju nemoćnima, bez mogućnosti da utječu na političku volju. U kvantitativnim pitanjima, na izravnu uputu da izaberu jednu od već navedenih, najčešće su naglašavali nedostatak političke volje kao primarnu prepreku razvoju politike mentalnog zdravlja. Zanimljivo je da su u kvalitativnim odgovorima sudionici kao nužan faktor promjene slabo prepoznali pritisak na političke elite. Osim toga, aktivnosti zagovaranja politike od strane stručnjaka i profesionalaca kao i povezanost političke elite i stručnjaka nisu se pojavili kao važni pokretači rasta i sazrijevanja hrvatske PMZ.

To nas vodi zaključku da stručnjake treba osnažiti i podržati da se izravnije uključe u stvaranje politike. Iako je PMZ niske kvalitete, postoje prilike kao i odgovornost profesionalaca u području mentalnog zdravlja da više surađuju, aktivnije participiraju u umrežavanju izvan svoje primarne discipline i da se s različitim akterima udružuju u zagovaračke koalicije. S obzirom na to da je jedan od ciljeva ovog rada, osim razfessionals' perceptions of quite poor quality of policy-making and impressions of extremely low knowledge-usage in this sector. The qualitative and quantitative data in our study suggests that multi-sectoral approach and interdisciplinarity of knowledge are seen as very poorly represented in the Croatian context, indicating that a holistic mental health policy is still in the phase of agenda setting, the first step of a policy development cycle. We can conclude that professionals in the MH sector evaluate policy-making in the field as unsystematic and based on outdated views of MH, highly dependent on top governmental bodies that are run by the political elite overall uninterested in MH.

Professionals and experts, according to our study, think about improvements of MHP in line with international guidelines. They stress a broad and holistic understanding of MH as a basis for MHP development. At the same time, data proves that MH professionals rarely consider themselves active players in the policy-making process. More frequently, they report on their practical work and interventions for direct users, and in general feel powerless and without any capacity to influence the political will. In quantitative questions, when they were asked directly to choose between the obstacles already stated, the lack of political will was most often stressed as the prime obstacle of MHP development. Interestingly, in qualitative answers, the participants showed poor recognition of the pressure on political elites as a necessary factor of change. Additionally, policy advocacy activities of experts and professionals as well as relationships between the political elite and experts did not come up as an important drive of growth and maturation of Croatian MHP.

This leads us to conclude that experts have to be supported and empowered to become more directly engaged in policy-making. Even though the MHP is of poor quality, there are opportunities and responsibilities for experts in the field of mental health to collaborate

matranja uloge ekspertize i prijenosa znanja, bio i informirati dionike, naši podatci daju nam priliku za sljedeće preporuke:

- Koliko god je to moguće stručna zajednica trebala bi biti izravno uključena u stvaranje politike i to zagovaranjem obuhvatne političke važnosti mentalnog zdravlja, putem javnih debata, podizanja svijesti i senzibiliziranja javnosti te oblikovanjem konkretnih prijedloga promjena politike i strateških smjernica za razvoj PMZ-a. Važno je da stručnjaci uvide svoj potencijal i moć te da ih njeguju u stručnim organizacijama i nevladinim organizacijama
- Budući da su sudionici naše studije izravno izrazili nužnost umrežavanja, voditelji stručnih zajednica trebali bi iznaći inovativnije načine umrežavanja: konkretne stručne zajednice i organizacije odgovorne su za nalaženje zajedničkog jezika i načina trajne komunikacije u sklopu zagovaračkih koalicija. Takvim ujedinjavanjem pritisak na političku elitu postao bi učinkovitiji, a polje mentalnog zdravlja lakše bi postalo političkim prioritetom
- Donositelji odluka i vladina tijela trebali bi uključiti raznovrsne stručnjake u sve faze stvaranja politike mentalnog zdravlja. Uključivanje rezultata znanstvenih istraživanja i znanja u praksu stvaranja politike trebalo bi biti intenzivnije, vidljivije i transparentnije i moglo bi ga se povećati čvršćim odnosima stvaratelja politike s istraživačkom i stručnom zajednicom.

more, to participate more actively in networking outside their primary discipline and to join advocacy coalitions of diverse actors that could raise their voices. Since one of the aims of this paper was, besides looking into the role of expertise and knowledge translation, to inform stakeholders, our data gives an opportunity for the following recommendations:

- As much as possible, the expert community should be directly devoted to policy-making by advocating broad MH political importance through public debates, raising awareness and sensitization of the public and developing concrete policy proposals and strategic guidelines for MHP development. It is important that experts realize their potential and power, which could be nurtured within expert organizations and NGOs.
- Since the participants of our study expressed the need directly, expert community leaders should find more innovative ways for networking outside of the box: specific professional communities and organizations have the responsibility to find a mutual language and ways for continuous communication within advocacy coalitions. When united, pressure on the political elite could be more effective and mental health could become a political priority more easily.
- Decision-makers and governmental bodies should involve diverse experts in all stages of mental health policy-making. The incorporation of research findings and knowledge into policy-making practice should be more intense, visible and transparent and could be enhanced by stronger relationships of policy-makers and the research and expert community.

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